MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2005

CIGNA HealthCare of Colorado, Inc.
3900 East Mexico Avenue
Suite 1100
Denver, Colorado 80210

NAIC Group Code 0901
NAIC Company Code 95604

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

CIGNA HealthCare of Colorado, Inc.
3900 East Mexico Avenue
Suite 1100
Denver, Colorado 80210

LIMITED MARKET CONDUCT EXAMINATION REPORT

as of
December 31, 2005

Examination Performed by

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

John E. Bell

Colorado Market Conduct Examiners

April 12, 2007

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of CIGNA HealthCare of Colorado, Inc. (the Company) was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-16-416, and 10-3-1106, C.R.S., which authorize the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its principal office located at 3900 East Mexico Avenue, Suite 1100, Denver, Colorado, 80210 and at the Colorado Division of Insurance offices at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2005, through December 31, 2005.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

John E. Bell

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COMPANY PROFILE

The following profile is based on information provided by the Company:

CIGNA HealthCare of Colorado, Inc. ("CHC-CO" or "Company") was incorporated in the State of Colorado as a for-profit corporation on November 20, 1985. The Company was issued a certificate of authority to operate as a health maintenance organization by the Colorado Division of Insurance on May 16, 1986.

The Company was originally incorporated under the name of CIGNA Healthplan of Colorado, Inc. On August 30, 1993, the corporate name was changed to CIGNA HealthCare of Colorado, Inc.

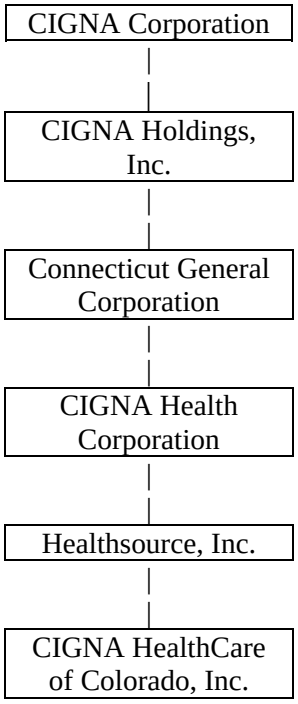
The Company is a wholly-owned subsidiary of Healthsource, Inc., which in turn is a wholly-owned subsidiary of CIGNA Health Corporation, which in turn is a wholly-owned subsidiary of Connecticut General Corporation, which in turn is a wholly-owned subsidiary of CIGNA Holdings, Inc., which in turn is a wholly-owned subsidiary of CIGNA Corporation, a publicly-held corporation.

Individual Enrollment as of 12/31/2005 (Individual Conversion Enrollment):	46
Small Group Enrollment as of 12/31/2005:	0*
Large Group Enrollment as of 12/31/2005:	36,556
Individual Written Premium as of 12/31/2005:	$388,666
Small Group Written Premium as of 12/31/2005 :	N/A
Large Group Written Premium as of 12/31/2005:	$129,146,830
Market Share (all Colorado Accident and Health Insurance):	1.76%

The NAIC group code for CIGNA HealthCare of Colorado, Inc. is 901 and the NAIC company number is 95604.

A relational organization chart is attached.

*The Company withdrew from the small group market effective January 1, 2005. Existing small groups were terminated at their renewal date beginning with January 1, 2005 renewals. Therefore, during the examination period, a decreasing number of small groups remained covered by the Company. References herein to small groups are references to such groups that had coverage in force during any portion of the examination period.


CIGNA Corporation
CIGNA Holdings, Inc.
Connecticut General Corporation
CIGNA Health Corporation
Healthsource, Inc.
CIGNA HealthCare of Colorado, Inc.

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (Division), in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), 10-16-416, and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the insurance business including health maintenance organizations, reviewed certain business practices of CIGNA HealthCare of Colorado, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health maintenance organizations. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or supplied by the Company. The limited market conduct examination covered the period from January 1, 2005, through December 31, 2005.

The examination included review of the following:

Company Operations and Management
Contract Forms
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization or health maintenance organization product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance

percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although CIGNA HealthCare of Colorado, Inc. and Connecticut General Life Insurance Company, Inc. are separate companies, there are certain policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in cases involving claims and utilization review, the Division would "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans - rules.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials - legislative declaration - definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-409, C.R.S.	Complaint system.
Section 10-16-416, C.R.S.	Examination.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review

Insurance Regulation 4-2-18	Concerning to Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado
Insurance Regulation 6-4-2	Standards for Safeguarding Customer Information

Company Operations and Management

The examiners reviewed Company management and administrative controls, the certificate of authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous limited market conduct examination dated February 25, 2000, which covered the period January 1, 1999 through December 31, 1999. The Company also underwent a financial examination by the Division, which covered the period of January 1, 1999 through December 31, 2003.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard HMO certificates, co-payment schedules and schedules of benefits;
- The Company's most commonly sold HMO group certificates marketed to employers;
- The Company's HMO conversion certificates, application/enrollment form, and supporting documents; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans and related forms were issued and/or certified with the Division between January 1, 2005 and December 31, 2005.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2005 through December 31, 2005, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) group cancellation/non-renewal/declination files

Claims

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although CIGNA HealthCare of Colorado, Inc.

and Connecticut General Life Insurance Company are separate companies, there are certain policies, procedures and forms that are common to both companies. Therefore, it was agreed that in the area of claims, the examiners would "deem" the findings to be applicable to the Company, even though the actual findings were identified in Connecticut General Life Insurance Company. Accordingly, the claims review portion of the Connecticut General Life Insurance Company market conduct examination dated April 12, 2007, is "deemed" to apply to the Company.

In order to determine the Company's compliance with Colorado's prompt payment of claims law as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days from claim receipt date;
- Fifty (50 non-electronic claims paid or denied beyond forty-five (45) days from claim receipt date;
- Fifty (50) claims paid or denied beyond ninety (90) days from claim receipt date;
- 100 paid claims; and
- 100 denied claims.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners selected a random sample of fifty (50) utilization review (UR) denial decision files from a summarized population of ninety-six (96). These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law.

In addition, the examiners reviewed a random sample of fifty (50) first level appeal files from a summarized population of ninety (90) files and the entire population of nine (9) voluntary second level appeal files in order to determine compliance with Colorado insurance law.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty (20) findings in which the Company did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Operations and Management: The examiners identified one (1) area of concern in their review of the Company's operations and management:

- **Failure, in some cases, to maintain records required for market conduct purposes.**

Contract Forms: The examiners identified eight (8) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and riders):

- **Failure to properly track member co-payments and co-payment maximums.**
- **Failure of forms to correctly define a "disabled dependent".**
- **Failure of forms to correctly describe the coverage to be provided for emergency medical services.**
- **Failure of forms, in some instances, to provide and/or disclose mandated coverage for hospitalization and general anesthesia for dental procedures for dependent children.** *(This was prior issue E8 in the findings of the market conduct examination report dated February 25, 2000.)*
- **Failure to properly define and/or list the mandated transplant benefits in its Basic and Standard health benefit plan certificates.**
- **Failure to properly title its Basic and Standard health benefit plan certificates.**
- **Failure to use and title Basic health benefit plan policy forms that are in compliance with Colorado insurance law.**
- **Failure of the Basic HMO forms, in some cases, to include all required preventive services.**

Cancellations/Non-Renewals/Declinations: There were no areas of concern identified during the review of the group cancellation/non-renewal files.

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company:

- **Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.**

- **Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.**

- **Failure, in some instances, to pay eligible claims.**

Utilization Review: The examiners identified eight (8) areas of concern in their review of the Company's Utilization Review procedures:

- **Failure, in some instances, to provide written notification of standard utilization review adverse determinations.**

- **Failure, in some instances, to include all required information in the written notice of first level appeal decisions.**

- **Failure, in some instances, to provide the title and qualifying credentials of the physician reviewer in first level appeal notification letters.**

- **Failure, in some instances, to consult with an appropriate clinical peer in reviewing first level utilization review appeals.**

- **Failure to disclose and/or provide the names, titles and/or credentials of the voluntary second level utilization review panel.**

- **Failure, in some instances, to ensure that a majority of the voluntary second level appeal review panel is comprised of health care professionals with appropriate expertise.**

- **Failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date.**

- **Failure, in some instances, to not discourage covered persons (or their representative) from requesting a face-to-face voluntary second level utilization review meeting.**

Results of previous market conduct examinations are available on the Division’s website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

CIGNA HEALTHCARE OF COLORADO, INC.

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some cases, to maintain records required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109(1), C.R.S., states in part:

Section 4. Records Required For Market Conduct Purposes

A. Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to, company operations and management, policyholder services, claims practices, rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years.

Section 5. Policy Records

A. The following records shall be maintained: A policy record shall be maintained for each policy issued. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as they are readily available to market conduct examiners as required under this regulation.

Section 11. Time Limits To Provide Records And To Respond To Examiners

A. An insurer/carrier shall provide any record requested by any examiner as required by Regulation 1-1-8 or such other time period as mutually agreed upon by the examiner and the insurer/carrier. When the requested record is not or cannot be produced by the insurer/carrier within the specified time period, a violation shall be deemed to have occurred, unless the insurer/carrier can demonstrate to the satisfaction of the commissioner that the requested record cannot reasonably be provided within the specified time period of the request through no fault of its own, its agents or its contracted third party administrator.

B. As a means to facilitate the examination, an insurer/carrier under examination shall provide a written response to an inquiry submitted by an examiner as required by Regulation 1-1-8 or such other time period as mutually agreed upon by the examiner and the insurer/carrier. When the requested response is not provided by the insurer/carrier within the specified time period, a violation shall be deemed to have occurred, unless the insurer/carrier can demonstrate to the satisfaction of the

commissioner that the requested response cannot reasonably be provided within the specified time period of the inquiry through no fault of its own, its agents or its contracted third party administrator.

Section 12. Records Usually Required For Examination

A. Records required for examination usually include, but are not limited to, the following, depending on the line of business;

C. Policyholder service; policyholder service (premium/billing notices; policy issuance/insured requested cancellations; correspondence files; reinstatements; policy transactions (cash surrenders, policy loan bank values, extended term, reduced paid-up, additional paid up, automatic premium loan, bank drafts and policy changes), late enrollment guidelines, annual policy reports, unearned premiums, assumptions, accelerated benefits, and consumer complaints (complaint register, complaint policies and procedures, complaint records, complaint disposition).

I. Utilization review: utilization review plan, utilization review policies and procedures annual utilization review certifications, utilization review monthly telephone reports, precertification records, nurse's notes, medical director reviews and appeals of noncertification records.

Colorado Insurance Regulation 1-1-8, Penalties And Timelines Concerning Division Inquiries And Document Requests, promulgated pursuant to §§10-1-109, 10-2-104, 10-3-109(3), and 10-16-109, C.R.S., states in part:

Section 4 Definitions

As used in this regulation:

D. "Examination Request/Comment Form" means a request for information made during the course of a formal market conduct or financial examination under §§ 10-1-201 to 207, C.R.S., and includes: 1) *A written request from the examiner for books, records, materials, information, or data necessary for examination of the company's operations*; and 2) A written comment from the examiner which identifies concerns related to company actions and requires additional information or acknowledgment from the company.

Section 5 Rules

E. Failure to provide a response, or *providing an incomplete response* to Division inquiries at any point in the handling of a matter, including during the course of a financial or market conduct examination, subjects the person to immediate imposition of a minimum $500 fine per act or occurrence. [Emphases added.]

During the review of the sample of utilization review and cancellation/declination/non-renewal files received during the examination period, the Company was unable to provide:

A. Records relating to the Company's utilization review process;
B. Records pertaining to the refund of premium owed, if any, to employer groups upon termination of contracts; and
C. Records pertaining to requests for the termination of coverage from employer groups and/or notice of termination of coverage from the Company.

Recommendation No. 1

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 1-1-7 and 1-1-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all records required for market conduct examination purposes are maintained and provided to the Division as required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure to properly track member co-payments and co-payment maximums.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonability clear; or
>
> (XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms require that covered members keep track of payment of their copayments and notify the Company when they have reached the copayment maximum set forth in their contract.

This requirement forces members to provide information that the Company should already be maintaining or aware of. It is the Company's responsibility to maintain records relating to copayments paid by members, and when the maximums have been reached in order to properly adjudicate claims. This requirement potentially places members in an adversarial position that could lead to delays and/or improper payment in the settlement of claims, or termination of coverage for cause in the case of unpaid copayments.

The Division recognizes that it is in the members' best interest to keep a record of their out-of-pocket expenses in order to ensure that they are receiving correct benefit payment; however, as the maximum out-of-pocket expenditure is a contractual provision, it is the Company's responsibility to administer it accurately.

The Company's forms state, in part:

The CIGNA HealthCare of Colorado, Inc. Point of Service certificate states in part:

Schedule of Copayments

> It is the Member's responsibility to maintain a record of Copayments which have been paid, and to inform the Healthplan when the amount reaches the Total Copayment Maximum.

The Company's Individual Conversion Agreement/Core Benefits/Colorado Design form states in part:

Section IX: Payments

Member Payments

> It shall be the responsibility of the SUBSCRIBER to maintain a record of Copayments which have been paid by the Membership Unit and to inform HEALTHPLAN when the amount of those Copayments reached the limit.

Form	Form Number
CIGNA HealthCare of Colorado, Inc. Point of Service	GSA-SOC-CO-C
Individual Conversion Agreement/Core Benefits/Colorado Design	CO.ICA-98/CHC-ICA94

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to indicate that members do not carry the primary responsibility of maintaining records relating to copayments and copayment maximums to ensure compliance with Colorado insurance law.

Issue E2: Failure of forms to correctly define a "disabled dependent".

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child *of any age* who is medically certified as *disabled* and *dependent* upon the parent. [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms are overly restrictive and misleading with regard to the definition of a disabled dependent. The Company's definition of a disabled dependent specifies that the child be "financially" dependent upon the parent; be "permanently and continuously" disabled; and that the disability be the result of "mental retardation or physical handicap". Colorado insurance law does not allow such qualifying restrictions to be placed on the definition of a disabled dependent.

Disability can be caused by factors other than mental retardation or physical handicap and in some cases, can be temporary in nature. Additionally, dependency of a disabled dependent in Colorado insurance law is not limited solely to financial dependency. The restrictions placed on the definition (and presumably eligibility) of disabled dependents by the Company appear to curtail coverage to individuals who would otherwise be entitled to such coverage under Colorado insurance law.

The Company's forms also fail to specifically disclose that the disabled dependent may be "of any age" and its contract wording is therefore misleading to members.

The CIGNA HealthCare of Colorado, Inc. Point of Service certificate states in part:

> **Section II. Enrollment and Effective Date of Coverage**
>
> Who Can Enroll as a Member
>
> To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below.
>
> B. To be eligible to enroll as a Dependent, you must:
>
> 1. be the legal spouse of the Subscriber; or
>
> 2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
>
> a. is unmarried and financially dependent upon the Subscriber for support; and
>
> i. has not yet reached age nineteen (19); or

ii. if the child is a full-time registered student in regular attendance at a secondary school, college or university, is financially dependent upon the Subscriber and has not yet reached age twenty-four (24). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and

Urgent Care benefits while at school; or

iii. the child is permanently and continuously incapable of self-sustaining support by reason of mental retardation or physical handicap, as certified by a physician. Proof of the child's condition and dependence must be submitted by you to us. During the next two (2) year period, we may, from time to time, require proof of the continuation of such condition and dependence. Thereafter, we may require such proof only once a year.

The Company's Individual Conversion Agreement/Core Benefits/Colorado Design form states in part:

Section VI: Eligibility

Dependent

To be eligible to enroll as a Dependent, an individual who is not ineligible by reason of any of the "Specific Causes for Ineligibility" of the Section must be at the time of enrollment:

CHILDREN. A natural child, adopted child, step-child, a child supported by the Subscriber pursuant to a valid court order or a child for whom the Subscriber is the legal guardian, if the child:

1. is unmarried and financially dependent upon the Subscriber for support; and

2. is a resident of the Service Area, PROVIDED, however, that a registered full-time student, who is eligible to enroll as a Dependent will be entitled to out-of-area emergency benefits under the "Emergency Services" Section while boarding at and in regular attendance as a registered full-time student at an accredited secondary school, or in regular attendance as a registered full-time student at an accredited college or university, located outside of the Service Area; and

3. a. has not attained his nineteenth (19th) birthday; or

   b. has not attained his twenty-fourth (24th) birthday (or such later birthday as specified in the Face Sheet or an attached rider) if a registered full-time student in regular attendance at an accredited secondary school, college or university; or

   c. is permanently and continuously incapable of self-sustaining support by reason of mental retardation or physical handicap, as certified by a physician. Proof of the child's condition and dependence must be submitted, by SUBSCRIBER or Member, to HEALTHPLAN. During the next two (2) year period, HEALTHPLAN may, from time to time, require proof of the

continuation of such condition and dependence. After that HEALTHPLAN may require proof no more than once a year.

Form	**Form Number**
CIGNA HealthCare of Colorado, Inc. Point of Service	GSA-SOC-CO-C
Individual Conversion Agreement/Core Benefits/Colorado Design	CO.ICA-98/CHC-ICA94

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to correctly reflect who qualifies as a disabled dependent as required by Colorado insurance law.

Issue E3: Failure of forms to correctly describe the coverage to be provided for emergency medical services.

Section 10-16-407, C.R.S., Information to enrollees, states in part:

(2) Every health maintenance organization shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. *No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency*. [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

Section 4. Definitions

H. "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment of bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

J. "Life or limb threatening emergency" shall have the same meaning as defined in Section 10-16-407(2), C.R.S.

Section 8. Emergency Services

A. *A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.* Under these same circumstances, a claim for emergency medical services necessary to screen and stabilize a covered person *shall not be denied for failure of the covered person or emergency service provider to secure prior authorization*. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency medical services necessary to screen and stabilize a covered person and *shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency*, or if a provision of federal, state or local law requires the use of a specific provider. [Emphases added.]

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated pursuant to 10-16-109, C.R.S., states in part:

> Section 4 Definitions
>
> No contract or evidence of coverage delivered or issued for delivery to any person by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below and in § 10-16-102, C.R.S. unless such definitions comply with the requirements of this section. Definitions other than those set forth herein and in § 10-16-102, C.R.S. may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and for the purpose of any terms used in a benefit contract of evidence of coverage:
>
> C. "Emergency services" means health care services provided in connection with any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms:

1) Allow the Company's Medical Director to determine what condition requires immediate medical attention as opposed to the "prudent lay person" standard;
2) Allow the Company to make claim determinations based on claim form coding and/or "final diagnosis" as opposed to the "prudent lay person" standard;
3) Require that emergency services be obtained from the member's PCP or other participating provider when within the Company's service area as opposed to the 911 or local equivalent standard; and

The Company's contract language contains provisions that are confusing and contradictory, and as such, could be confusing to Member's when trying to obtain emergency medical services.

The CIGNA HealthCare of Colorado, Inc. Point of Service certificate states in part:

> **Section IV. Covered Services and Supplies**
>
> **Emergency Care and Urgent Care**
>
> **Emergency Service Both In and Out of the Service Area**
>
> *If you require specialty care or a hospital admission, your PCP or the CIGNA HealthCare 24-Hour Health Information Line* [SM] *will coordinate it and handle the necessary authorizations for care or hospitalization*. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.
>
> The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, *will be the basis for the determination of coverage, provided that such symptoms reasonably indicate an emergency*. [Emphases added.]

The Company's Individual Conversion Agreement/Core Benefits/Colorado Design form states in part:

> **Section XI: Service and Benefits**
>
> **Ambulance Service**
>
> A Member is entitled to ambulance service and access to services through 9-1-1 or local equivalent, *provided such service is Medically Necessary and authorized by the HEALTHPLAN Medical Director,* or the use of such service is determined to have been an Emergency Service, as defined in the "Emergency Services" provision of this Section. [Emphasis added.]
>
> **Emergency Services**
>
> 1. **Definition of Emergency Services.** Emergency Services are: (a) medical, surgical, hospital and related health care services and testing, including ambulance service and access to services through 9-1-1 or local equivalent, required to treat a sudden unexpected onset of a bodily injury or a serious illness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment of bodily functions.; and (b) screening and stabilization services, even if an emergency condition is found not to exist, in circumstances where a prudent layperson having an average knowledge of health services and medicine and acting reasonably would have believed an emergency medical condition or life or limb threatening emergency existed.
>
>   Included are conditions which produce loss of consciousness or excessive bleeding; *or which may otherwise be determined by the HEALTHPLAN Medical Director in accordance with generally accepted medical standards, to have been a condition requiring immediate medical attention.*
>
> 2. **Emergency Services Within the Service Area.** *Emergency Services within the Service Area must be obtained from the Primary Care Physician or other Participating Providers*. Participating Providers are available on call twenty-four (24) hours a day, seven (7) days a week, to assist Members needing Emergency Services. Emergency Services obtained other than as set forth above will be covered: (a) *if the HEALTHPLAN Medical Director, on review,* determines that the Member could not have reasonably been expected to exercise control over where or by whom the Emergency Services were rendered. [Emphases added.]

Form	**Form Number**
CIGNA HealthCare of Colorado, Inc. Point of Service Individual Conversion Agreement/Core Benefits/Colorado Design	GSA-SOC-CO-C CO.ICA-98/CHC-ICA94

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-407, C.R.S., and Colorado Insurance Regulations 4-2-17 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to correctly describe the coverage to be provided for emergency medical services as required by Colorado insurance law.

Issue E4: Failure of forms, in some instances, to provide and/or disclose mandated coverage for hospitalization and general anesthesia for dental procedures for dependent children.
(This was prior issue E8 in the findings of the market conduct examination report dated February 25, 2000.)

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (12) Hospitalization and general anesthesia for dental procedures for dependent children
>
> (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102(14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:
>
> (I) The child has a physical, mental, or medically compromising conditions; or
> (II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
> (III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
> (IV) The child has sustained extensive orofacial and dental trauma.

It appears that the Company is not in compliance with Colorado insurance law in that its "Individual Conversion Agreement/Core Benefits/Colorado Design" policy form fails to list, describe or advise members that coverage shall be provided for hospitalization and general anesthesia for dental procedures for dependent children who meet the criteria set forth in § 10-16-104(12), C.R.S. Failure to list these services, as mandated by Colorado insurance law, deprives members of their notification of entitlement to receive these services and benefits.

Furthermore, the Company's "Exclusions and Limitations" section of the policy form states: "Any services and benefits which are not described in the 'Services and Benefits' Section or in an attached Rider are excluded from coverage under this Agreement." This contract language applies additional restrictions on the members' ability to receive these mandated services and benefits.

This issue appears to be a repeat of Issue E8 from the Limited Market Conduct Examination Report of CIGNA HealthCare of Colorado, Inc. dated February 25, 2000.

Form	**Form Number**
Individual Conversion Agreement/Core Benefits/Colorado Design	CO.ICA-98/CHC-ICA94

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to correctly reflect the mandatory hospital and anesthesia benefits to be provided to dependent children for dental procedures in accordance with Colorado insurance law.

In the limited market conduct examination for the period January 1, 1999 to December 31, 1999, the Company was cited for failure to provide mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children. The violation resulted in Recommendation #19 of Final Agency Order O-00-288, that the Company "shall provide documentation to the Division that it has amended its policy contracts to list or describe coverage for general anesthesia for dental procedures for dependent children". Failure to comply with the previous order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue E5: Failure to properly define and/or list the mandated transplant benefits in its Basic and Standard health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
December 1, 2004

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Health Benefit Plan without Specified Mandates*", "*Basic High Deductible Health Benefit Plan*", "*Basic High Deductible Health Benefit Plan without Specified Mandates*".

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

Benefit Grids:

2004 COLORADO BASIC HEALTH BENEFIT PLANS WITHOUT SPECIFIED MANDATES: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
BASIC HEALTH BENEFIT PLAN WITHOUT SPECIFIED MANDATES		IN-NETWORK	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
24. ORGAN TRANSPLANTS [18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, *kidney/pancreas*, and bone marrow *for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.* [Emphases added.]			
	50% coinsurance	70% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

[18] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

2004 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	**STANDARD PREFERRED PROVIDER PLAN**		**STANDARD HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK[2]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, *kidney/pancreas*, and bone marrow *for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.* [Emphases added.]			
	80% coinsurance	80% coinsurance	60% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

It appears that the Company is not in compliance with Colorado insurance law in that the description of covered transplant procedures contained in the Company's "Individual Conversion Agreement/Core Benefits/Colorado Design" contract form does not contain all of the transplant procedures required to be covered under the Basic and Standard health benefit plans; does not correctly list all covered diseases; and/or provides coverage for transplants that are not included in the Colorado Basic and Standard health benefit plans.

The Company's form appears to fail to provide coverage for simultaneous kidney/pancreas transplants while incorrectly listing a pancreas transplant as being covered. In addition, the Company's form fails to list the specific conditions that are mandated to be covered for bone marrow transplantation and does not provide for peripheral stem cell support for the covered bone marrow transplants.

Additionally, the Company's "Exclusions and Limitations" section of the contract states: "Any services and benefits which are not described in the "Services and Benefits" Section or in an attached Rider are excluded from coverage under this Agreement." This contract language restricts the members' ability to receive the mandated transplant benefits and services.

The Division notes that the Company's "Colorado Health Plan Description Forms", used as the copayment schedules for the Company's Basic and Standard health benefit plans, do contain the correct

description of the mandated transplant coverage. However, this form states: "**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contain all terms, covenants and conditions of coverage." This language appears to restrict benefits for transplants to those listed in the contract and is misleading and confusing to the member in regard to their benefits.

The Company's "Individual Conversion Agreement/Core Benefits/Colorado Design" states in part the following:

> **SECTION XI: Services and Benefits**
>
> **Organ Transplant Services**
>
> A Member is entitled to receive benefits for human organ and tissue transplant services at limited facilities throughout the United States, as designated by the HEALTHPLAN, subject to the conditions and limitations below.
>
> A. **DEFINITION OF TRANSPLANT SERVICES**. Transplant services are the recipient's medical, surgical and hospital services, inpatient immunosuppressive medications, and organ procurement required to perform any of the following human to human organ or tissue transplants: kidney, cornea, bone marrow, heart, heart/lung, lung, liver or pancreas.

Form	Form Number
Individual Conversion Agreement/Core Benefits/Colorado Design	CO.ICA-98/CHC-ICA94

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly display all transplant benefits mandated by Colorado insurance law.

Issue E6: Failure to properly title its Basic and Standard health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4. Rules

A. 1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

B. *The basic and standard health benefit plans shall be identified as specified below.*

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (Basic Health Benefit Plan without Specified Mandates, Basic High Deductible Health Benefit Plan or Basic High Deductible Health Benefit Plan without Specified Mandates)] for Colorado".

2. Each small employer carrier shall title and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO)] Standard Health Benefit Plan for Colorado". [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its "Individual Conversion Agreement/Core Benefits/Colorado Design" health benefit certificate for the Colorado Basic and Standard health benefit plans are combined in one document as opposed to being titled separately as required by Colorado insurance law.

Additionally, this formatting of the Colorado Basic and Standard health benefit plans is potentially confusing to members when attempting to determine the benefits provided to them under their contract. The contract makes no differentiation as to the benefits provided under the Basic or standard health benefit plan. While the Company provides a copy of the Colorado Health Plan Description Form for either the Basic or Standard health benefit plan (depending on the member's choice) as a "Schedule of Copayments", this form states:

"**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage" and "Consult the actual policy to determine the exact terms and conditions of coverage".

Form	Form Number
Individual Conversion Agreement/Core Benefits/Colorado Design	CO.ICA-98/CHC-ICA94

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect the required title in accordance with Colorado insurance law.

Issue E7: Failure to use and title Basic health benefit plan policy forms that are in compliance with Colorado insurance law.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4. Rules

A. 1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (Basic Health Benefit Plan without Specified Mandates, Basic High Deductible Health Benefit Plan or Basic High Deductible Health Benefit Plan without Specified Mandates)] for Colorado".

It appears that the Company is not in compliance with Colorado insurance law in that its "Attachment 1—Covered Preventive Services" form, used in conjunction with its Colorado Basic health benefit plan certificate, contains incorrect and misleading wording. This form states, in various places, "Not covered under the *Basic Limited Mandate Health Benefit Plan*". [Emphasis added.]

In addition to referencing the incorrect Basic plan, this wording could potentially be confusing to members in that it excludes coverage under a plan that is different from what they have purchased from the Company.

Form	Form Number
Attachment 1—Covered Preventative Services	None found

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to ensure they are properly titled and has removed any language that may be confusing to members to ensure compliance with Colorado insurance law.

Issue E8: Failure of the Basic HMO forms, in some cases, to include all required preventive services.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
December 1, 2004

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Health Benefit Plan without Specified Mandates"*, "Basic High Deductible Health Benefit Plan", or "Basic High Deductible Health Benefit Plan without Specified Mandates." [Emphasis added.]

Benefit Grids:

2004 COLORADO BASIC HEALTH BENEFIT PLANS WITHOUT SPECIFIED MANDATES: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all co-insurance percentages listed are what the carrier will pay for service. For the HMO plan, the percentage copay listed is what the member will pay.)

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
Basic Health Benefit Plan without Specified Mandates		**IN-NETWORK**	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)	None	None	None	*None* [emphasis added]

Attachment 1

Covered Preventive Services [1]

Age 65 and older	1 influenza immunization every year
	1 pneumococcal vaccine at or after age 65
	Females: screening pap smears not to exceed 1 per year
	1 Td every ten years
	1 age appropriate health maintenance visit every year
	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months [Emphasis added.]
	Either annual fecal occult blood testing or 2 colorectal visualization between ages 50 and 74
	Males: Prostate screening as specified in state law **(Not covered under the Basic Health Benefit Plans without Specified Mandates and the Basic High Deductible Health Benefit Plans without Specified Mandates.)**

It appears that the Company is not in compliance with Colorado insurance law in that its Basic HMO Individual Conversion Plan Without Specified Mandates health plan description form states that mammography and clinical breast exams for females aged 65 to 74 are not covered benefits under the plan. One screening mammogram and clinical breast exam is covered every 12 months under the Basic Health Benefit Plan Without Specified Mandates plan for females aged 65 to 74.

The examiners note the correct coverage is listed in the Company's "Attachment 1 - Covered Preventive Services" form. However, the inconsistency of the Company's contracts and related documents has the potential to be misleading to the members in determining what coverage and/or services are available to them under their plan.

The Company's Basic HMO Individual Conversion Plan without Specified Mandates health plan description form states in part the following:

PART B: SUMMARY OF BENEFITS

31. SIGNIFICANT ADDITIONAL COVERED SERVICES	
(1) Preventative Cancer Screening	
-Mammography (age 65-74)	*Not Covered* [emphasis added]
-Pap test (age 19 and older)	No copayment (100% covered)
-Colon (age 50 and older)	No copayment (100% covered)
-Prostate	Not Covered

Form	Form Number/Date
Basic HMO Individual Conversion Plan without Specified Mandates health plan description form	May 2005

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to comply with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.
>
> *(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,937*	50	30	60%

(*2% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 3,937 electronic claims that had not been paid, denied or settled within thirty (30) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that thirty (30) of the electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,580*	50	28	56%

(*5% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) non-electronic claims from a total summarized population of 2,580 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears that the Company is not in compliance with

Colorado insurance law in that twenty-eighty (28) of the non-electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,440*	50	30	60%

(*1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 2,440 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that thirty (30) of the claims in the sample were not paid, denied or settled within the required ninety (90) calendar days after receipt.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. …

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,937*	50	27	54%

(*2% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 3,937 electronic claims that had not been paid, denied or settled within thirty (30) days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest to either the provider or the insured on twenty-seven (27) clean electronic claims that were not paid, denied or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,580*	50	18	36%

(*5% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) non-electronic claims from a total summarized population of 2,580 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest to either the provider or the insured on eighteen (18) clean non-electronic claims that were not paid, denied or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 CALENDAR DAYS - PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,440*	50	16	32%

(*1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 2,440 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay a ten percent (10%) penalty on the total amount ultimately allowed on the claim to the insured or health care provider on sixteen (16) of the claims not paid, denied, or settled within ninety (90) calendar days after receipt.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that interest is paid on clean claims that are not paid, denied, or settled within the time frames required by Colorado insurance law and that, except where fraud is involved, a penalty is paid on all claims not paid, denied, or settled within ninety (90) calendar days after receipt as required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay eligible claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; …

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
14,453	100	6	6%

From a population of 14,453 claims denied by the Company between January 1, 2005 and December 31, 2005, a randomly selected sample of 100 denied claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time six (6) claims were denied, the Company was in possession of all information necessary for it to pay the claims, which were covered under the terms of the contract.

- Three (3) claims were incorrectly denied for unknown reasons;
- Two (2) claims were incorrectly denied as being not covered; and
- One (1) claim was incorrectly denied for exceeding plan coverage.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its quality controls to ensure that its claims processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims to assure compliance with Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to provide written notification of standard utilization review adverse determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 6. Standard Utilization Review

B.(1)(a)(i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, *a health carrier shall* make the determination and *notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.*

(ii) *Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.*

E.(1) A notification of an adverse determination under this section shall, in a manner set calculated to be understood by the covered person, set forth:

(2) A health carrier must provide the notice required under this section in writing, either on paper or electronically. [Emphases added.]

STANDARD UTILIZATION REVIEW ADVERSE DETERMINATIONS
WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	43	4	9%

The examiners reviewed a randomly selected sample of fifty (50) HMO standard utilization review adverse determination files. Of the fifty (50) files identified for review, the Company was unable to provide documentation on five (5) of the files. Additionally, two (2) of the files selected for review were determined to be utilization review determinations that were approved by the Company. As a result, the effective sample size was forty-three (43) files. It appears that the Company did not meet the requirements of Colorado insurance law in that in four (4) of the files reviewed, the examiners were unable to find any documentation that written notification of the adverse determination was provided to either the covered person, or the covered person's provider.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notification is provided for all utilization review adverse determinations as required by Colorado insurance law.

Issue K2: Failure, in some instances, to include all required information in the written notice of first level appeal decisions.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10. First Level Review

J. A first level review decision involving an adverse determination issued pursuant to Subsection G shall include, in addition to the requirements of Subsection I:

(6) If the carrier offers a voluntary second level appeal, a description of the process to obtain a voluntary second level review, including:

(b) The right of the covered person to:

(i) Request the opportunity to appear in person before a review panel of the health carrier's designated representatives;
(ii) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;
(iii) Present the covered person's case to the review panel;
(iv) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
(v) If applicable, ask questions of any representative of the health carrier on the review panel; and
(vi) Be assisted or represented by an individual of the covered person's choice;

(c) A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, *including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker*.

(d) A description of the procedures for obtaining an independent external review of the adverse determination pursuant to insurance regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination. [Emphases added.]

LEVEL 1 APPEALS – Second Level Appeal Rights

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	12	39%

LEVEL 1 APPEALS – Rights to Other Benefits Under the Plan

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	28	90%

LEVEL 1 APPEALS – Obtaining Independent External Review

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	28	90%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by covered persons or their representatives. Of the fifty (50) files reviewed, thirty-one (31) involved adverse first level appeal decisions. The Company offers a voluntary second level appeal process. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In twelve (12) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement fully outlining the covered person's second level appeal rights as set forth in Colorado Insurance Regulation 4-2-17(10)(J)(6)(b).

- In twenty-eight (28) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement of the covered person's rights as set forth in Colorado Insurance Regulation 4-2-17(10)(J)(6)(c).

- In twenty-eight (28) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement of procedures for obtaining an independent external review of the adverse first level appeal determination as set forth in Regulation 4-2-17(10)(J)(6)(d).

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that first level appeal decision notification letters include all information as required by Colorado insurance law.

Issue K3: Failure, in some instances, to provide the title and qualifying credentials of the physician reviewer in first level appeal notification letters.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10. First Level Review

I. The decision issued pursuant to Subsection G shall set forth in a manner calculated to be understood by the covered person:

(1) *The name, title and qualifying credentials of the physician evaluating the appeal*, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposed of this section, the physician and consulting clinical peers shall be called "the reviewers".) [Emphasis added]

LEVEL 1 APPEALS – Title and Qualifying Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	8	26%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by "covered persons" or their representatives. Of the fifty (50) files reviewed, thirty-one (31) were adverse determinations that required disclosure of the title and qualifying credentials of the reviewing physician.

It appears that the Company did not meet the requirements of Colorado insurance law in that in eight (8) out of thirty-one (31) first level appeal files reviewed, the Company's first level appeal decision notification letter did not contain the title and qualifying credentials of the physician that evaluated the appeal request as set forth in Colorado Insurance Regulation 4-2-17(10)(I)(1).

Note: Although Colorado Insurance Regulation 4-2-17(10)(I)(1) mandates disclosure of the name, title and qualifying credentials of the reviewing physician, along with the qualifying credentials of the peer reviewer of all first level appeals, the examiners are not citing the Company for failure to do so in the appeals that resulted in a reversal of the original utilization review decision. It was felt that these determinations were in the interest of the consumer. However, the Company should take steps to ensure make sure that its first level appeal practices conform to Colorado insurance law whether the original adverse utilization review determination is upheld or reversed.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notifications of first level appeal decisions contain all information required by Colorado insurance law.

Issue K4: Failure, in some instances, to consult with an appropriate clinical peer in reviewing first level utilization review appeals.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 4. Definitions

D. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Section 10. First Level Review

E. (1) First level reviews shall be evaluated by a physician *who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer*. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. [Emphasis added.]

LEVEL 1 APPEALS – Appropriate Clinical Peer

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	2	6%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by covered persons or their representatives. Of the fifty (50) files reviewed, thirty-one (31) were adverse determinations that required a consultation with a clinical peer.

It appears that the Company did not meet the requirements of Colorado insurance law in that in two (2) out of thirty-one (31) first level appeal files reviewed, the first level appeal review by the Company did not involve consultation with an appropriate clinical peer, nor did the reviewing physician appear to be a "clinical peer" as set forth in Colorado Insurance Regulation 4-2-17(10)(E)(1).

Note: Although Colorado Insurance Regulation 4-2-17(10)(E)(1) mandates an appropriate clinical peer consultation of all first level appeals of an adverse utilization review determination, the examiners are not citing the Company for failure to do so in the appeals that resulted in a reversal of the original utilization review decision. It was felt that these determinations were in the interest of the consumer. However, the Company should take steps to ensure that its first level utilization review appeal practices conform to Colorado insurance law whether the original adverse utilization review determination is upheld or reversed.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that utilization review first level appeals meet the requirements of Colorado insurance law.

Issue K5: Failure to disclose and/or provide the names, titles and/or credentials of the voluntary second level utilization review panel.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

H. A decision issued pursuant to Subsection G shall include:

(2) *The names,* titles and qualifying credentials *of the review panel*…
[Emphasis added]

VOLUNTARY SECOND LEVEL APPEALS – Names, Titles and Credentials of Review Panel

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	7	7	100%

The examiners reviewed the entire population of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representatives. Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. An additional appeal file contained a decision that was overturned prior to review by the review panel, and therefore was also not reviewed. The remaining seven (7) files were determinations that required disclosure of the names, titles and qualifying credentials of the members of the review panel.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all seven (7) of the voluntary second level utilization review decisions reviewed, the Company's decision notification letter and/or attachment provided to the covered person and/or their representative(s), did not contain the names, titles, and/or qualifying credentials of the members of the review panel as required by Colorado Insurance Regulation 4-2-17(11)(H)(1).

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that its voluntary second level utilization review meets the requirements of Colorado insurance law.

Issue K6: Failure, in some instances, to ensure that a majority of the voluntary second level appeal review panel is comprised of health care professionals with appropriate expertise.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

F.(2)(b) *A health carrier shall ensure that a majority of the persons* reviewing a grievance involving an adverse determination *are health care professionals who have appropriate expertise in relation to the case presented by the covered person.* [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Make-Up of Review Panel

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	7	2	29%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second-level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. An additional appeal file contained a decision that was overturned prior to review by the review panel, and therefore was also not reviewed. The remaining seven (7) files were determinations that require that the majority of the Company's voluntary second level review panel be comprised of health care professionals with appropriate expertise relating to the case being reviewed.

It appears that the Company did not meet the requirements of Colorado insurance law in that in two (2) out of seven (7) voluntary second level utilization review decisions reviewed, the Company failed to ensure that the majority of the review committee was comprised of health care professionals with the appropriate expertise in relation to the case being presented by the covered person and/or their representative(s) as set forth in Colorado Insurance Regulation 4-2-17(11)(F)(2)(b).

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that its voluntary second level review panel includes a majority of persons who are health care professionals with appropriate expertise in relation to the case being reviewed as required by Colorado insurance law.

Issue K7: Failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

> Section 11. Voluntary Second Level Review
>
> G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:
>
> (1) The review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for voluntary second level review. *The covered person shall be notified in writing at least twenty (20) days in advance of the review date.* The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Notification of Review Panel Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	8	6	75%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. The remaining eight (8) files were files that required notification to the covered person at least twenty (20) days prior to the scheduled review date.

It appears that the Company did not meet the requirements of Colorado insurance law in that in six (6) of the eight (8) files reviewed, the Company did not provide the covered person or their representative(s) notice of the scheduled review date at least twenty (20) days prior to the review date as required by Colorado Insurance Regulation 4-2-17(11)(G)(1).

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that covered persons are notified in writing at least twenty (20) days in advance of the second level review date as required by Colorado insurance law.

Issue K8: Failure, in some instances, to not discourage covered persons (or their representative) from requesting a face-to-face voluntary second level utilization review meeting.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision.

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(2) *Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting*. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Request a Face-to-Face Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	8	8	100%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. The remaining eight (8) files were cases where the review panel was scheduled.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all eight (8) of the files reviewed, the Company discouraged the covered person and/or their representative(s) from requesting a face-to-face meeting by not fully disclosing the location of the review panel meeting, or stating that the location is "teleconference".

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that it does not discourage covered persons (or their representatives) from requesting and/or attending voluntary second level utilization review panel meetings in person as required by Colorado insurance law.

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